C+D
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7 November 2009

Spot the difference

Can improved pack design prevent errors?

See page 30

Wrap up kids' cold & flu symptoms with CALPROFEN

When children need fast, effective relief from the symptoms of colds and flu, sore throats, aches and pains, recommend CALPROFEN. Nothing fights their fever faster or provides greater symptom relief throughout the night

The makers of Calpol have kids' colds & flu covered this winter

Calprofen 100 mg/5 ml Oral Suspension Ibuprofen Product information: **Presentation:** Suspension containing 100mg ibuprofen per 5ml. **Uses:** Treatment of mild to moderate pain, antipyretic, post-immunisation pyrexia, reducing fever and flu and minor sprains or strains. **Dosage:** Pain and fever: *Infants 3-6 months, weighing over 5kg:* One 2.5 ml dose may be taken 3 times in 24 hours; *Infants 6-12 months:* 2.5ml dose three times a day; *Children 1-2 years:* 2.5ml three to four times a day; *Children 3-7 years:* 5ml three to four times a day; *Children 8-12 years:* 10ml three to four times a day. Post-immunisation fever: 2.5ml dose followed by one further 2.5ml (50mg) dose six hours later if necessary. No more than 2 doses in 24 hours. **Contraindications:** Hypersensitivity to ingredients, or to aspirin or other NSAIDs. Peptic ulceration, perforation or GI bleeding. Concomitant use with NSAIDs. Severe hepatic, renal or heart failure. Women in the last trimester of pregnancy. **Precautions:** The elderly; women tying to conceive; history of GI toxicity; concomitant medications increasing the risk of GI toxicity; hepatic or renal dysfunction; bronchial asthma or allergic disease; hypertension or heart failure; SLE and mixed connective tissue disease; chronic inflammatory disease. Not to be used in combination with anticoagulants, corticosteroids, lithium, methotrexate, zidovudine, diuretics and antihypertensives. **Pregnancy and lactation:** Not recommended. **Side effects:** Hypersensitivity, skin reactions, GI disturbances, oedema, hypertension, cardiac failure, exacerbation of asthma and bronchospasm, headache, haematological disorders. Rarely: hepatic dysfunction, peptic ulcer, perforation or gastrointestinal haemorrhage, acute renal failure, papillary necrosis, exacerbation of ulcerative colitis and Crohn's disease and symptoms of aseptic meningitis. **RRP (ex-VAT):** 200ml bottle £4.40; 100ml: £2.91. **Legal category:** 200ml: P; 100ml: GSL. **PL holder:** McNeil Products Ltd, Maidenhead, Berkshire, SL6 3UG. **PL number:** 200ml: 15513/0120; 100ml: 15513/0147. **Date of preparation:** July 2009. 04883

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> A MORE PROACTIVE RESPONSE TO RP AT THE OUTSET COULD HAVE PREVENTED SOME OF THE PITFALLS WE NOW FACE

The results of this week's C+D RP Survey (p4) brought comparisons between pharmacists and the animal kingdom. Representative bodies stand accused of acting like ostriches as the fallout from the regs became apparent for the first time.

Admin burden was about all that frontline pharmacists said they had to show for RP so far, according to our findings. Industry leaders had two years to anticipate and offset some of these burdens for their members, critics say, and yet guidance was still being updated as we approached deadline day.

It's a view that resonates with some of our survey respondents. Several added vitriolic comments about what they considered the lack of fight from pharmacy representatives in opposing the RP rules. Many more appeared bemused by what benefits RP actually delivers in return for all the form filling.

But look at the headline findings from the survey and, begrudgingly or not, most have done the leg work to comply. Nearly three quarters are highly confident in their understanding of the regs, almost all are clear on who their RP is and most have spent several hours or more reviewing procedures.

But if grassroots pharmacists are so anti the RP regs, you have to consider why so few spoke out when the proposals were first put out by the Department of Health.

The rules change was open to debate for nearly two years and included a full public consultation. But, out of more than 20,000 community pharmacists affected by the change, a mere 311 exercised their right to reply. It's not just the politicians who have a voice. A more proactive response to RP at the outset could have prevented some of the pitfalls we now face.

Getting greater engagement with grassroots pharmacists will not happen overnight though. The 100-page consultations that explain current professional changes are a major turn off for time poor pharmacists wanting to speak out. There is surely a role for pharmacy organisations, the DH and C+D in refining these weighty documents and making them more accessible.

Perhaps opinions could be inspired through more imaginative use of email, text message or tweets. The challenge will then be for all parties to use this extra feedback to lobby more effectively around legislative changes. If they can do so then it can only encourage more pharmacists to engage the next time around.

The RP lesson for the entire pharmacy sector is to stop acting like ostriches. When the next big professional change looms we must roar together like lions instead.

Max Gosney, News Editor

RP paperwork makes job harder, survey says

EXCLUSIVE C+D poll reveals nearly half feel worse off under RP regs

Zoe Smeaton
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The responsible pharmacist (RP) regulations have made pharmacists' jobs more difficult, according to nearly half of those responding to a C+D survey.

Industry leaders have also expressed frustration at the lack of clarity over the regulations, which came into force on October 1.

But despite these issues, C+D found most pharmacists had implemented the changes and were confident practising under the new rules.

A common complaint was the additional paperwork required by the regulations to produce new SOPs and complete a pharmacy record. One pharmacist surveyed said time was "wasted filling in a logbook – [it's] sheer stupidity", while another commented that the regulations brought "complexity with no benefits".

Most pharmacists had spent at least two hours preparing for the regulations, with 27 per cent saying it had taken them more than five hours. Over three quarters of the 100 pharmacists surveyed told C+D they were confident practising under the regulations.

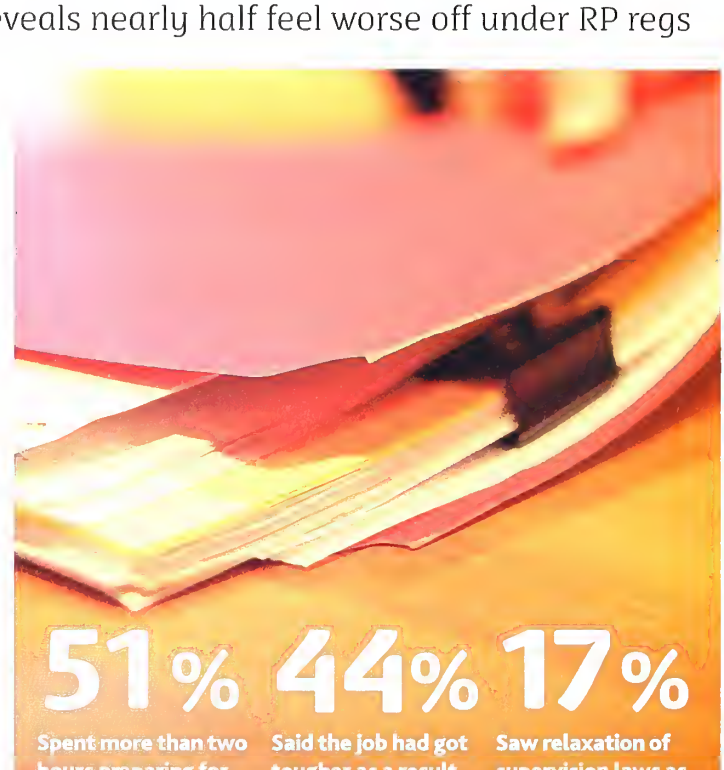
Twenty two per cent reported being "a little bit unsure" about the regulations and just 2 per cent said they were "clueless and very worried".

Industry leaders including Paul Bennett, superintendent pharmacist at Boots, called for clarity on outstanding issues, such as the fact that absences could currently be regarded as a breach of NHS terms of service.

Stephen Fishwick, head of NPA external communications, said given the outstanding issues it was "not surprising" that the survey found some bemusement as to the benefits of the rules.

The new rules added to the already increasing administrative burden on pharmacists, according to John D'Arcy, commercial director at Rowlands.

But the expectation on pharmacists to make a record that they were the responsible pharmacist and publicly display this information was "reasonable", Jeremy Holmes, RPSGB chief executive, told C+D. And Janice Perkins, superintendent at The Co-operative Pharmacy, said the regulations would enable "benefits further down the line".



Sector accused of ostrich approach

The pharmacy profession should have acted sooner to anticipate some of the teething troubles surrounding RP regulations, experts have said.

Kirit Patel, chief executive at Day Lewis, said he thought some of the issues still requiring clarification represented a failure of the large organisations and representative bodies to anticipate problems earlier and make noises about them. Paul Bennett, superintendent pharmacist at Boots, agreed some of the issues could have been spotted sooner.

Jeremy Holmes, RPSGB chief executive and registrar, told C+D the Society had responded to the consultation on the regulations and stressed: "There was a very thorough process for the development of the standards and guidance."

And regulations were always going to be challenged, queried and tested as new situations arose, John D'Arcy, commercial director at Rowlands, added. **ZS**

RP survey soapbox

Readers' comments on RP:

"Being responsible for SOPs takes more time, which I do not have in a normal working day."

"Time is wasted filling in a logbook – sheer stupidity. It's obviously an ill thought-out wheeze."

"More forms to fill out, more time wastage and more rules to follow."

"The conflict with working time directive must be resolved. We are not robots and need a proper break."

"RP is a total waste of resources, the RPSGB should have worked harder to oppose it."

"After all the work we have done on skill mix, why can't fully trained technicians, for example, assemble out-of-hours for later checking by a pharmacist?"

"Customers expect to see a pharmacist in a pharmacy. It is our USP."

Sector unsure about supervision

Over 80 per cent of pharmacists are unconvinced about the benefits of flexible supervision allowing them to be away from the dispensary.

Half of those surveyed by C+D said they were "not sure" how they felt about the rules, with 32 per cent saying they saw them as a threat to viability.

Industry leaders said with the debate on supervision yet to come it could be difficult to gain an informed view. But they stressed that the failure to consider supervision alongside the responsible pharmacist regulations had been a missed opportunity.

The comments came as the Pharmacists' Defence Association (PDA) launched a campaign to make remote supervision the central issue in upcoming RPSGB elections. The PDA pledged to back pharmacists opposed to remote supervision who stand for the Society's new professional leadership boards or national assembly.

The PDA is opposed to remote supervision, which could see pharmacists able to supervise pharmacies without being physically present in the dispensary.

RPSGB chief executive and registrar Jeremy Holmes said supervision was just one of the issues facing pharmacy. Members would want to know how candidates intended to address upcoming issues, he stressed. **ZS**

MPs demand update on decriminalising errors

Progress report sought on DH negotiations with MHRA and CPS

Jennifer Richardson
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A cross-party group of MPs has asked the Department of Health (DH) for an "urgent update" on the decriminalisation of dispensing errors.

Chair of the all-party pharmacy group (APPG) Howard Stoate MP wrote to England's chief pharmaceutical officer Keith Ridge at the end of last month, requesting a "progress report" on the DH's negotiations with medicines regulator the MHRA and the Crown Prosecution Service (CPS).

It was at an APPG meeting in June that Dr Ridge pledged to push the CPS to avoid prosecuting one-off dispensing errors while the MHRA reviewed the legislation on such criminal charges. Dr Stoate told C+D: "We felt after nearly five months it was time for a gentle reminder."

Dr Stoate was hoping the DH had made "good progress in negotiations with the CPS with a view to getting reassurance that pharmacists who have made honest errors won't face prosecution", and which would lead to "a timely change in the law over the next year or two".

Dr Howard Stoate: "After nearly five months it was time for a gentle reminder"

A CPS spokesperson told C+D it was "considering draft guidance" on dispensing errors and wanted to finalise it "as soon as possible". However, she stressed: "There's nothing in that guidance to say there's an amnesty in prosecution for pharmacists... if we get a case we will have to review it."

Dr Stoate reacted cautiously to the news, saying the APPG would review the guidelines when available, but he added: "No-one wants an amnesty where there has been wrongdoing or negligence but we do want an amnesty where there has been an honest mistake."

Earlier this year the MHRA refused to provide details of its discussions with the CPS after C+D requested them under the Freedom of Information Act. The medicines regulator could see "no overriding public interest in disclose", it said.

Summer hopes for revised funding

Contractors must wait until next summer at the earliest for an accurate funding deal, according to the latest timetable for the cost of service inquiry.

The inquiry is now set to report next April, according to Department of Health estimates.

Negotiations on a revised pharmacy contract will follow "closely on the conclusion of the inquiry", PSNC told C+D. The organisation refused to estimate timescales for these talks.

However, C+D understands that translating the inquiry findings into a workable pay deal could take several months.

The setback marks the latest delay to the cost of service inquiry, which had originally been set to conclude this year. This was then revised to early 2010 with a funding deal predicted by the spring.

But progress appears to be underway, with accountancy firm PricewaterhouseCoopers unveiled as the supplier for the inquiry by PSNC and the DH this week.

Details around how the inquiry will be carried out remain unclear, however.

When asked how many contractors will be asked to submit evidence, PSNC said: "No further details are confirmed at present."

A PSNC spokesperson told C+D that the inquiry had started recently, but declined to specify a date.

The DH said future funding arrangements would be linked with quality.

Contractors have grown increasingly vocal over shortfalls in funding in the past two years. Lloydspharmacy chief Richard Smith became the most recent to demand a shake up, at last month's C+D conference. He urged contract negotiators to broker a deal that reflected the true costs of running a modern pharmacy. **MG/JC**

Support pharmacy's next generation, says Jonathan Mason in his latest videoblog

www.chemistanddruggist.co.uk/mason

In brief

Boots' double digit growth

Double digit income growth from UK pharmacy services contributed to an increase in Alliance Boots' revenue of almost 12 per cent in the first half of 2009-10.
www.chemistanddruggist.co.uk

Bodies oppose fees

Four leading pharmacy bodies have joined forces to oppose the RPSGB's proposed 4 per cent rise in premises fees for 2010. The NPA, CCA, PSNC and AIMp said the £7 increase to £175 would divert funding from services.

Scots lobby on CoE

The RPSGB and Community Pharmacy Scotland lobbied MSPs on the Scottish Government's promised review of control of entry at the ruling Scottish National Party's Inverness conference last month.

Co-op distribution centre

The Co-operative Pharmacy's £16 million, 190,000sq ft national distribution centre, which was officially opened last week, will give its pharmacies "a degree of protection" against drug shortages by removing third party wholesalers, the multiple has said.

Personalised budgets

The DH has launched a consultation on personalised health budgets. Under the scheme, patients could receive direct payment to purchase health or social care treatments, potentially including pharmacy support such as multi-dosage systems. The consultation closes on January 8.
tinyurl.com/yzytp8z

Cannabis row resignation

The pharmacist representative of a government drugs misuse panel has resigned after the chair's removal by the home secretary. RPSGB fellow Marion Walker stepped down after Professor David Nutt was forced to resign by Alan Johnson following a row over the safety of cannabis.

RP survey winner

Craig Stein of Lloydspharmacy in Wishaw, Lanarkshire, has won an iPod Shuffle for completing C+D's RP survey.

In brief

Anti-counterfeit TV ad

The RPSGB has joined forces with Pfizer to launch part two of the manufacturer's anti-counterfeiting campaign. A TV advert warning the public of the dangers of purchasing medicines from unregulated websites was due to screen as C+D went to press.
www.chemistanddruggist.co.uk

Alupent discontinued

Boehringer Ingelheim will discontinue Alupent syrup (orciprenaline sulphate), which is used to relieve reversible airway constriction in asthma and similar conditions, from September 30, 2010. The manufacturer said the decision came because more specific products were now available.

AZ discontinuations

AstraZeneca is to discontinue Heminevrin syrup 300ml (clomethiazole edisilate) and beta blocker Betaloc SA tablets (metroprolol tartrate). The firm will continue supply in the UK until stocks are exhausted.

Phenytoin in 28-tab pot

Pharmaceutical company Wockhardt has launched a 28-tablet pot of the anticonvulsant phenytoin. The packaging's design is geared towards patient safety, with a clear font and minimal corporate branding following feedback from pharmacists and patient safety associations.

Keele University

Keele University has opened its new school of pharmacy building, following a £2.2 million redevelopment project. The revamp includes a "cave", a teaching area that can double up as a pharmacy or GP surgery.
www.chemistanddruggist.co.uk

Diabetes double for men

Men over 50 are nearly twice as likely to have undiagnosed type 2 diabetes than their female counterparts, Diabetes UK has warned. Over 20 per cent of men with diabetes do not know they have it, suggested research in the charity's official journal, Diabetic Medicine, this week.

GPhC changes address to separate from RPSGB

Future regulator shows independence despite sharing location

Chris Chapman
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The General Pharmaceutical Council (GPhC) has distanced itself from the RPSGB by using a different address – despite being located in the same building.

The move comes as the GPhC attempts to satisfy government demands for pharmacy regulation to be carried out by an independent organisation from April next year.

The GPhC is currently located in the Society's headquarters at 1 Lambeth High Street. However, the future regulator has been assigned the address 129 Lambeth Road.

Visitors to both the Society and GPhC enter through the same door and reception.

Bob Nicholls, chairman designate of the GPhC, said the arrangement, which gives the appearance of the two bodies being separated geographically, balanced "the principle of separation and independence with pragmatism".

Same building, different address: home of both the GPhC and the Society

He said: "We're going to route our members and other people through the GPhC door, and a different address, so to the world out there it's beginning to look different."

The GPhC was set up after the government ruled the RPSGB could no longer both regulate and represent pharmacists.

A white paper in 2007 called for a new independent regulatory body to provide greater transparency and accountability to the public.

However, Mr Nicholls said the regulator would still have some reliance on the Society's resources in the short term.

"We use some of the RPS corporate services. We're not going to have our own HR or finances – we're not big enough."

The decision on whether to continue arrangements with the Society would be made independently, Mr Nicholls added. The GPhC team would comprise around 120 members, two-thirds of whom would be from the RPSGB's existing regulatory team, Mr Nicholls said.

Self-selection of P meds and EHC provision still to be decided

No decision has been made about self-selection of P medicines and service provision standards, the future pharmacy regulator has said.

The statement comes after a consultation included questions over whether standards governing the two areas should change.

One question asks whether there should still be no explicit ban on pharmacists offering P medicines for self-selection.

However, GPhC adviser and former RPSGB chief inspector Jackie Giltrow insisted no decision had been made, and that the consultation was gauging opinion.

Another question asks if pharmacy services, such as EHC, should be provided regardless of moral or religious objection.

Ms Giltrow said the question had been raised by patients and the consultation "wanted to explore" the issue.

The consultation is open until January 12, 2010 and will inform standards for the GPhC when it takes over pharmacy regulation from April next year. See the document at www.chre.org.uk/consultation/175.

Evidence review condemns aspirin guidelines

Low-dose aspirin should no longer be used to prevent heart attack and stroke in the absence of diagnosed heart disease, according to a Drug and Therapeutics Bulletin (DTB) review.

The review of the latest evidence concludes the "benefits and harms of aspirin in this setting may be more finely balanced than previously thought", even in individuals estimated to be at high risk.

The DTB authors do not question the value of aspirin in secondary prevention, but say its benefits in primary prevention are cancelled out by the dangers of gastrointestinal bleeds, and that it has a negligible effect on death rates overall.

The DTB review calls into question earlier guidelines, which advocate aspirin in primary prevention for groups including the over-50s with diabetes, and those with high blood pressure.

It argues that the current evidence also shows doctors should review all patients currently taking low-dose aspirin for primary prevention.

Earlier guidelines were published by the Scottish Intercollegiate Guidelines Network, the European Society of Cardiology, and the Joint British Societies. **GA**

How did aspirin come to be a staple of primary prevention – and why have experts changed their minds?
See p25

Levonelle® One Step is on telly.
Expect an increase in demand.

Levonelle One Step has launched its first ever TV campaign, raising awareness of emergency contraception and its availability at pharmacies among an even greater number of women. **Stock up to meet demand.**

Levonelle® One Step™ 1500 microgram tablet
Prescribing Information (Refer to the Summary of Product Characteristics (SmPC) before prescribing)
Presentation: One tablet containing 1500µg levonorgestrel. **Uses:** Emergency contraception within 72 hours of unprotected intercourse or failure of contraception. Not recommended for young women under 16 without medical supervision. **Dosage and administration:** One tablet taken as soon as possible, preferably within 12 hours, and no later than 72 hours after unprotected intercourse. Vomiting, or other causes of malabsorption (such as Crohn's), might impair the efficacy of Levonelle One Step. If vomiting occurs within 3 hours of taking the tablet, another tablet should be taken immediately. Use at any time in the menstrual cycle unless period is overdue. After use, advise using barrier methods until next period. Regular hormonal contraception can be continued. **Contraindications:** Hypersensitivity to any of the ingredients of the preparation. **Warnings and precautions:** Levonelle One Step is suitable only as an emergency measure. Advise women presenting for repeat courses to consider long-term methods of contraception. Levonelle One Step does not prevent a pregnancy in every instance. If timing of intercourse is uncertain or occurred more than 72 hours earlier, conception may have already occurred. Following treatment, if the next menstrual period is abnormal or more than five days late, women should be referred to a doctor so that pregnancy may be excluded. If pregnancy occurs, evaluate for ectopic pregnancy. Ectopic pregnancy risk is low. Ectopic pregnancy may continue despite uterine bleeding. Explain importance of follow-up appointment and possible alteration to timing of next period (few days earlier or later). Exclude pregnancy in users of regular hormonal contraception if no bleeding occurs in the next pill-free period. Not recommended for women with severe hepatic dysfunction. Emergency contraception does not protect against sexually transmitted infections. Repeat administration within a menstrual cycle is not advisable due to possible disturbances of the cycle. Efficacy might be impaired in women with malabsorption syndromes or by interaction with concurrent drugs including barbiturates (e g primidone), phenytoin, carbamazepine, herbal medicines containing Hypericum perforatum (St John's wort), rifampicin, ritonavir, rifabutin, griseofulvin. Medicines containing levonorgestrel may increase the risk of ciclosporin toxicity. Women with malabsorption syndromes or on interacting medicines should be referred to a doctor. Levonelle One Step contains 142 5mg lactose. Take this into account for women with galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption. Epidemiological studies indicate no adverse effects of progestogens on the foetus but there is no data available for doses greater than 1 5 mg levonorgestrel. Animal studies showed virilisation of female foetuses at high doses. Levonorgestrel is secreted into breast milk. Advise breast feeding women to take the tablet immediately after a breast feed. **Side-effects:** Nausea, low abdominal pain, fatigue, headache, dizziness, breast tenderness, vomiting and diarrhoea. Bleeding patterns may be temporarily disturbed. **Trade price:** £13 83 per tablet **Legal classification:** P **PL Number:** PL 05276/0020 **PL Holder** Medimpex UK Limited, 127 Shirland Road, London, W9 2EP **Distributor:** Schering Health Care Limited, The Brow, Burgess Hill, West Sussex, RH15 9NE Levonelle One Step is a registered trademark of Bayer Schering Pharma AG (formerly Schering AG) Date of revision: March 2009

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9LVN04 Date of preparation: April 2009

Dispensary talk

Should dispensing staff be liable for dispensing errors?

"The way things stand now, no. The final check is with the pharmacist. If they're ACTs, then yes, but if they're normal dispensers, no."
Aina Osunkunle, K and A Pharmacy, Gateshead,

"Yes, of course. It's obvious if they're dispensing and make an error they've got to take some level of blame."
Neeraj Salwan, Salwan Pharmacy, Johnstone

Web verdict

Yes 68%

No 32%

Armchair view: It's a tough message for staff, as most voters think they should take responsibility when they make a mistake.
Next week's question:
How much extra red tape have you had to deal with under RP?
Vote at
www.chemistanddruggist.co.uk

Support package aims to seize family planning role

P&G bids to increase pharmacy's share of pregnancy testing market

James Clegg

Procter & Gamble (P&G) has launched a training package to help pharmacists boost business by offering advice to couples hoping to conceive.

The Wish for a Baby initiative consists of an accredited eight-module CPD course plus marketing material and advice for store layout.

The programme aims to help pharmacists cash in on the £41 million pregnancy testing market, according to P&G. P&G pharmacy channel manager Joanna Dee said: "Some people come and ask for advice but for many it's difficult. That's why we are offering both training to help [pharmacists] talk to customers and materials that can help educate people at the shelf."

P&G is offering the support service free to boost sales of its ovulation and pregnancy test brand, Clearblue. Category sales increased 26 per cent in the month following the launch of a limited pilot version of Wish for a Baby, P&G reported.

Alongside predicted commercial gains the scheme also looked to enhance the professional reputation of pharmacists, Ms Dee added.

"We are seeking to help couples who are trying to conceive to realise that they have a true expert they can speak to with total confidence about the subject area," she said.

The scheme is currently running in 1,700 Lloydspharmacy stores and 146 independents. Ms Dee said that recruitment is ongoing.

Photo MEN Syndication

Boots has confirmed it will carry out an investigation after a customer suffered an extreme allergic reaction, possibly due to its Boots Colour hair dye brand. The multiple said it was in talks with Zoe Vernon (pictured), from Didsbury to help establish the cause of her reaction. A Boots spokesperson said the product would continue to be available while the investigation was ongoing. The multiple stressed the importance of following instructions on products and carrying out a skin sensitivity test 48 hours before use. JC

N Ireland debates regulatory independence at PSNI AGM

The future of the independent regulation of Northern Ireland's pharmacists featured heavily at PSNI's annual general meeting.

Sean O'Hare, former director of pharmacy at Belfast Trust, asked why PSNI was so committed to keeping regulatory powers when other UK regions would report to the General Pharmaceutical Council (GPhC) from April.

Speaking on behalf of PSNI, head of public affairs Mark Neale outlined that in other professional groupings, for example social care, there was an appetite for regional regulation.

In the UK, with the exception of Northern Ireland, there had not been a history of regional regulation and this might explain the lack of push in Wales and Scotland, he said.

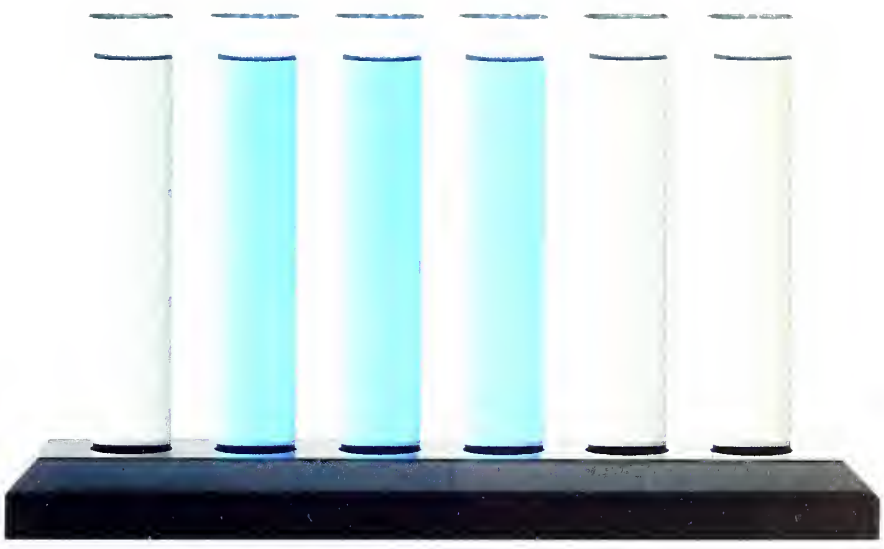
NI's chief pharmacist, Norman Morrow, wondered why PSNI could not switch to the GPhC while growing PSNI as a professional leadership organisation. He asked PSNI to make public the number of responses to a recent consultation on the Pharmacy Forum, PSNI's attempt to split the leadership and regulatory responsibilities.

This information has yet to be presented to Council and, once complete, findings would be made public, he was told by PSNI's director.

Belfast pharmacist Terry Maguire said that PSNI would be unviable if its regulatory responsibility was withdrawn, denying pharmacists local leadership with the devolved administration. **Contrib**

"It's a very different picture in Northern Ireland"

Terry Maguire on smoking cessation – see p14



From the 4th November Generics [UK] Ltd will be trading as Mylan.

Mylan, the new reference in healthcare.

Mylan
your life

Chew over soothing Rescue gum

Rescue Chewing Gum is a new addition to the Nelsons Rescue range.

The gum is formulated to be soothing and is naturally flavoured with orange and elderflower.

The liquid centre of the gum contains four drops of the same combination of five flower essences as Rescue Remedy.

According to Nelsons, new research shows that chewing gum can help relieve anxiety, improve alertness and reduce stress.

The gum is suitable for vegetarians and comes in a portable box, which is handy for use on the go.

Price and Pip code: £3.95/37g, 348-4227
Nelsons
Tel: 0800 289 515
www.rescueremedy.co.uk

Retail talk

Are parents confused about new guidelines for children's cough and cold medicines?

Yes 96%

No 4%

Off the shelf view:
A fairly unanimous verdict this week, highlighting how important it is for pharmacists to reassure worried parents with the latest advice. By next March, children's cough and cold medicines for ages six to 12 will only be available with P status.

This week's question:
Do you believe the recession will affect your Christmas gift sales? Vote at **www.chemistanddruggist.co.uk/prodnews**

Handy Strepsils tube for people on the go

Reckitt Benckiser is introducing its Strepsils lozenges for sore throat relief in convenient new tube packaging. Strepsils Handy Tubes are available in Honey & Lemon and Cool flavours.

The compact pack is designed to be sold in tandem with traditional blister packs, but has been developed to sit alongside medicinal confectionery as a front of counter product, says Reckitt Benckiser.

"Strepsils Handy Tubes have been developed specifically for independent retailers and pharmacies," comments Stefan Gaa, the company's marketing director.

The launch will be supported by a £4 million national TV, radio and bus advertising campaign which starts this month. The bus advertising is targeted at commuters.

Sampling activity is planned for Strepsils Cool and point of sale material is available for pharmacies.

Prices and Pip codes:
Honey & Lemon £1.46/10, 347-2586;
Cool £1.95/10, 347-2602
Reckitt Benckiser
Tel: 01482 326151

Market focus

- The £115 million sore throat relief market is growing by 1 per cent (AC Nielsen MAT value sales October 3, 2009).
- Strepsils is the No 1 brand for sore throat relief (AC Nielsen MAT value sales September 5, 2009).

All round flu advice on the web

Reckitt Benckiser's healthcare brands Lemsip, Nurofen and Strepsils have teamed up with Dettol Disinfectant Spray to launch a new website designed to give the public easy access to information and advice on flu.

The website aims to educate consumers about the simple measures that can be taken to help keep flu at bay and, if caught, how to treat the symptoms effectively.

The easy to navigate site features relevant advice for all ages including pregnant women. It also includes guidance on school hygiene.

The site enables consumers to download leaflets with top tips on how to help prevent the spread of flu this winter, allowing people to keep the information in accessible places such as on fridges or on work notice boards.

Reckitt Benckiser
Tel: 01482 326151
www.fluandyou.co.uk

HbA1C results in four minutes

Quotient Diagnostics is launching a new analyser for HbA1C that is suitable for pharmacy testing.

The Quo-Test has been developed to provide accurate results from a single drop of blood to help improve the management of diabetes.

The compact analyser is designed to be quick and easy-to-use, delivering laboratory results in four minutes.

The analyser's features include automatic calibration and print and download options.

Quotient Diagnostics
Tel: 01932 220124

Check what's on TV

www.chemistanddruggist.co.uk/prodnews

In brief

Mylan update

Generics (UK) Ltd is now trading as Mylan and its products are to be repackaged under the brand from the New Year. The packs will be designed to make it easier to identify products and strengths to help enhance both dispenser and patient safety. If space allows, the dispensing label will also appear on the pack front.
Mylan; tel: 01707 853077

Tots starter pack

Brother Max, which specialises in baby and toddler products, has launched a new starter pack suitable for independent pharmacies. The pack contains 30 products and includes a free merchandising unit.
Trade price: £139.68 plus VAT
Brother Max
Tel: 01886 887758

New look Bio-Kult

Protexin has introduced softer new packaging for its Bio-Kult probiotic capsules, designed to make the supplement more appealing to consumers. The formulation remains unchanged.
Prices and Pip codes:
£14.63/60, 348-2973;
£28.82/120, 348-2999
Protexin; tel: 01935 822921

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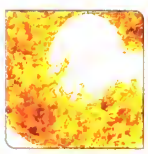
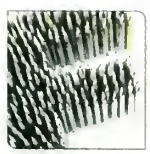


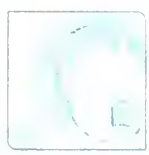
Burning pain

Crawling pain



Stabbing pain

Shocking pain



Freezing pain

Action on pain!

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The Charity for Healthier Backs

PAIN CONCERN

Trigeminal Neuralgia Association UK

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www.nerve-pain.co.uk

TALK TO YOUR PATIENTS ABOUT NEUROPATHIC PAIN AND THE TREATMENTS AVAILABLE

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Getting the measure of quality outcomes

I support the move towards a quality and outcomes pay framework (QOF) for MURs rather than simply rewarding quantity. But such a service should not be implemented without a clear remuneration package, supported by IT, that could reflect the varying complexities of different diseases or conditions.

MURs should be the backbone of all pharmacists' service provision. They represent an unparalleled opportunity to generate income, demonstrate pharmacy's contribution to patients' wellbeing, particularly those with long-term conditions, and offer real value to the broader primary care environment. However, to be successful in this environment, pharmacists must collect population-based data to show their PCT how they benefit patients.

Whether driven by QOF or simply by a desire to demonstrate value, measurements relating to adherence, incidence of side effects and patients' understanding of their medicines, are general to all MURs. However, condition or disease-related measurements frequently provide more meaningful opportunities to demonstrate patient outcomes and could reduce hospital admissions as well as have a significant impact on patients and their families.

We recently worked with The Co-operative Pharmacy to support the introduction of a respiratory MUR pilot. Asthma is a long-term condition that could be well managed in pharmacy. The pharmacists used the asthma control test (ACT), an easy and time efficient self-reporting questionnaire, to assess how well controlled the patient's asthma had been for the previous month and, in combination with In-Check Dial – a respiratory flow measurement device – how well they used their inhaler.

Pharmacists then asked patients to keep a record of their ACT scores and repeated the ACT at intervals. They also recorded the number of patients for whom they had demonstrated inhaler technique.

Central to the success of the programme was early collaboration with local surgeries. Pharmacists approached the practice nurse and GPs to demonstrate the value of the In-Check Dial and agree a process for referrals. Significantly, during the programme, patient ACT scores improved and a measurable impact on outcomes was demonstrated.

Measuring the impact of MURs, and setting quality standards, will help illustrate the potential value pharmacy can deliver as well as helping their patients to get the most from their medicines.

Pharmacists must seek to record health measurements that are achievable, implementable, sustainable, auditable, underpinned by clinical health outcomes, and utilise IT resources.

Only when these steps are taken will the potential of MURs, and the value of pharmacists, be realised.

Linda Stephens, national pharmacy advisor, GlaxoSmithKline

> TO BE SUCCESSFUL IN THIS ENVIRONMENT, PHARMACISTS MUST COLLECT POPULATION-BASED DATA TO SHOW THEIR PCT HOW THEY BENEFIT PATIENTS

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Sticking up for dispensers

I usually like to discuss topical news articles from these pages with my staff, but there is one item in last week's issue that I hope they don't notice. If my dispenser thought she could be liable for a criminal conviction for a dispensing error, she would want a pay rise at the very least, and would possibly consider her position. And I wouldn't blame her.

The news that a dispenser has lost her appeal against a conviction for a single dispensing error (C+D, October 31, p5) is a surprise, particularly as the pharmacist on duty was also convicted. I'm paid much more than my staff because I'm the one who should be ultimately responsible, and the idea that both pharmacist and dispenser can be culpable for the same mistake simply doesn't add up for me.

Ensuring the accuracy of every dispensed prescription is my main raison d'être; if the dispenser is responsible then I'm largely redundant.

Anne enjoys her job and takes it extremely seriously, following SOPs to the letter, but I have repeatedly assured her that I have to spot her mistakes because I'm the one who carries the can. We record her errors, like mine, for audit purposes in order to improve dispensary efficiency only. If she became liable for individual dispensing errors it would ruin the whole ethos of our working relationship.

The judge in this case suggested that anyone involved in the "system of supply" should be liable for their errors. This could include counter staff who hand out dispensed prescriptions and the delivery driver I assume? These positions would never be filled if prospective employees were aware of the potential risk they are taking. Ultimately the whole system could collapse because there is not enough money to pay all pharmacy staff for the huge extra responsibility they would be taking on.

And if all at the pharmacy are liable, then GPs' receptionists should be too. I'm aware of cases where they have printed off the wrong repeat, for example, and patients suffer, yet receptionists seem to be immune from any sort of scrutiny.

This decision sets a dangerous precedent and runs contra to current policy, where individual pharmacists are responsible for virtually everything that happens within a 50 yard radius of where they stand. And it does little to support the concept that pharmacists should be released from the dispensary bench if they remain responsible for what goes on there. Why have a responsible pharmacist if they're only half responsible? I wonder if I should display a notice with Anne's name on it so patients know who else they can sue when fishing for a bit of compensation.

I have yet to see a statement of outrage from any pharmacy body. While pharmacists may theoretically have the new PLB on their side in such cases, and the PDA if they're a member, who will be standing up for dispensers?

> THAT PHARMACIST AND DISPENSER CAN BE CULPABLE FOR THE SAME MISTAKE SIMPLY DOES NOT ADD UP FOR ME

Smoking cessation where it belongs

Jennifer Richardson (C+D, October 3, p22) paints a depressing picture of pharmacy smoking cessation services for England and, to some degree, for Scotland. At four weeks, cessation rates are lower than for other service providers and since, in Scotland certainly, pharmacy is a popular choice for quitters, the low cessation rates are of concern.

It's a very different picture in Northern Ireland, with pharmacy supporting over 30 per cent of smokers who quit in 2008-09. And with a cessation rate of 54 per cent at four weeks, pharmacy is the most effective service. There are discrepancies, however, with some pharmacy services achieving over 60 per cent success at four weeks, which brings the average up.

We are fortunate to have a national service specification and, for those accredited providers, the right to supply NRT on the same pharmacy voucher used for the national minor ailments scheme. DHSSPS had the good sense to see the benefits pharmacy brings to smoking cessation and to invest in it.

In my pharmacies we have been providing a smoking cessation service for over 15 years; we even charged patients for it in the early 1990s. When the area health and social services boards initially paid pharmacies for the service it was only partially successful as patients needed to visit their GPs to get NRT – some of whom refused. The real change came with the provision of NRT as part of the service and we developed the capacity to take on as many smokers as possible. In our business plan, our target is 100 smokers a year – in the current year we have enrolled over 200. Colleagues tell me they don't have the time for this, but then they mistake time for capacity.

We refuse to deal, there and then, with someone enquiring about our service; access to the service is only by appointment. This may seem to act against the accessibility of community pharmacy, but we have found that those who turn up for their appointment are more committed to quitting, which may explain our above average cessation rates at four weeks and at 52 weeks.

Community pharmacy should be a central pillar to the NHS smoking cessation service provision and can achieve high cessation rates. That said, we need a national service specification within which NRT supply is standard and varenicline is also allowed. We also need ongoing support for service providers, particularly those reporting low cessation rates. Perhaps a mechanism to allow those obtaining high cessation rates to share their learnings with those who need help to increase their results?

Terry Maguire is a community pharmacist in Northern Ireland

> COLLEAGUES TELL ME THEY DON'T HAVE THE TIME, BUT THEN THEY MISTAKE TIME FOR CAPACITY


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Features

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The 'soft skills' you will learn from our free MUR workshops will help you build even stronger relationships with your patients, earning their trust and loyalty by providing them with excellent advice. We think this can only be a good idea.

Pfizer *Listening to pharmacy*

a healthy partnership™

HP-0250 Date of preparation October 2014

Buying medicines on line can be a real danger We're helping patients smell a rat

As part of Pfizer's *a healthy partnership*™ programme, we've been listening. We know you want to protect patient safety, so do we.

Our Get Real, Get a Prescription campaign educates people about the dangers of counterfeit medicines and the hazards of buying prescription-only medicine without a prescription from unregulated, online sources. The campaign includes outdoor, online and a hard-hitting commercial.

This campaign is supported by the MHRA, the Patients Association, Royal Pharmaceutical Society of Great Britain and the Nation's Cholesterol Charity, H.E.A.R.T.

We want patients to know that the only safe way to obtain medicines is through a registered pharmacist. We have materials you can use with your patients to help them sniff out the dangers - just email us on ahealthypartnership@pfizer.com.

Or to find out more about the Real Danger initiative visit: www.realdanger.co.uk

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HP-0250. Date of preparation: October 2009

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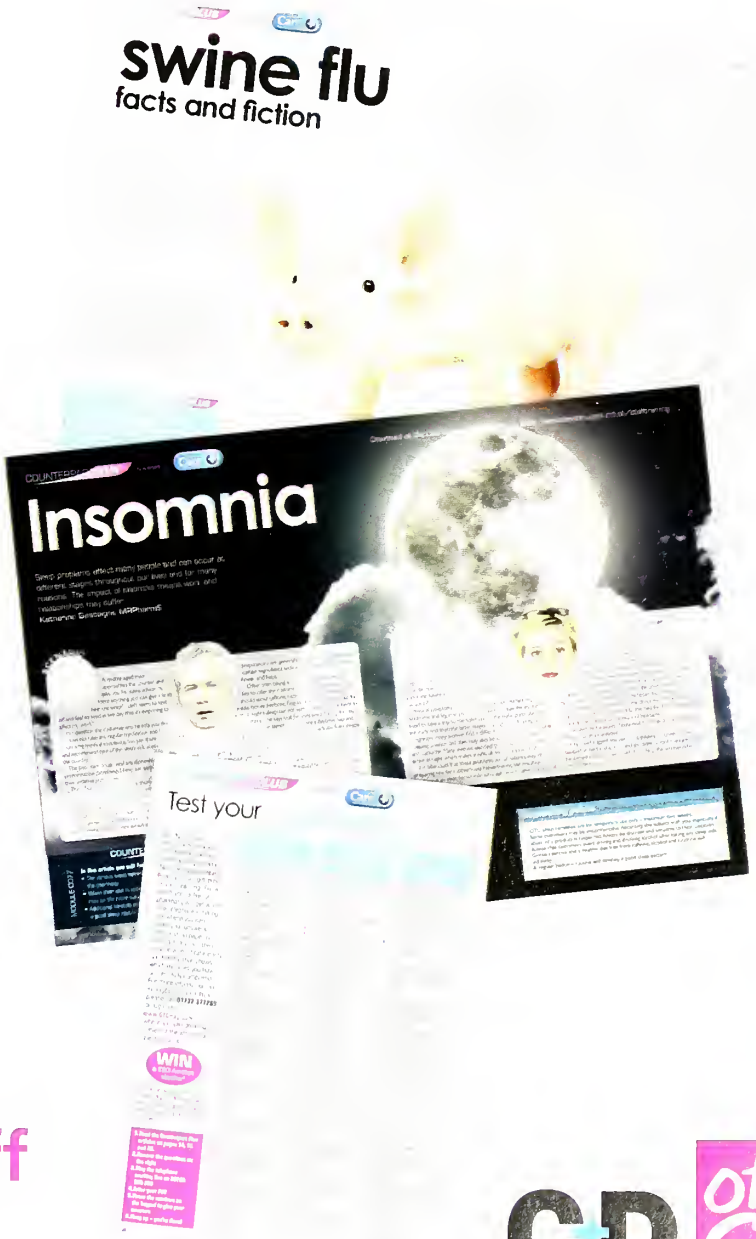

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NEW ellaOne® is the first emergency hormonal contraceptive that is licensed for use within 5 days of unprotected intercourse (UPI). ellaOne® provides sustained efficacy across 5 days offering you emergency hormonal contraception you can count on.[1]

ABBREVIATED PRESCRIBING INFORMATION (UK)
ellaOne® (ulipristal acetate). Please refer to the SmPC before prescribing ellaOne® **Presentation:** White/off-white, round curved tablet engraved "11" on both faces. **Indications:** Emergency contraception within 120 hours (5 days) of unprotected sexual intercourse or contraceptive failure. **Dosage:** One 30mg tablet to be taken orally as soon as possible, but no later than 120 hours after unprotected intercourse or contraceptive failure; with or without food. Another tablet should be taken if vomiting within 3 hours of intake. ellaOne can be taken at any point during the menstrual cycle. Pregnancy should be excluded. *Renal or hepatic impairment:* no specific dose recommendations can be made. *Severe hepatic impairment:* not recommended. *Children and adolescents:* Safety and efficacy only established in women ≥18 years. **Contra-indications:** Hypersensitivity to the active substance or excipients. Pregnancy. **Special warnings and precautions for use:** Concomitant use with an emergency contraceptive containing levonorgestrel is not recommended. Use in severe asthma insufficiently controlled by oral glucocorticoid is not recommended. Emergency contraception only: women should be advised to adopt a regular method of contraception. May reduce contraceptive action of regular hormonal contraception; subsequent acts of intercourse should be protected by a reliable barrier method until next menstrual period. Repeated administration within the same menstrual cycle is not advisable. No data for unprotected intercourse more than 120 hours before intake. Does not prevent pregnancy in every case; delay of >7 days in next menstrual period, abnormal bleeding at menses, or symptoms of pregnancy, exclude pregnancy. If pregnancy occurs, possibility of an ectopic pregnancy should be considered. Menstrual periods can sometimes occur earlier or later than expected by a few days. In ~6%, menstrual periods occurred >7 days early. In ~20% a delay of >7 days occurred, and in 5.1% the delay was >20 days. Contains lactose monohydrate; patients with galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should avoid. **Drug interactions:** Ulipristal acetate is metabolized by CYP34A *in vitro*. No specific drug interaction studies have been performed *in vivo*. **Potential for other medicinal products to affect ulipristal acetate:** CYP34A inducers (e.g. rifampicin, phenytoin, phenobarbital, carbamazepine, ritonavir, St John's Wort/Hypericum perforatum) may reduce plasma concentrations of ulipristal acetate and decrease efficacy, even if stopped enzyme inducer within last 2-3 weeks. Concomitant use not recommended. Concomitant administration of medicinal products that increase gastric pH (e.g. proton pump inhibitors, antacids and H2-receptor antagonists) may reduce plasma concentrations of ulipristal acetate and decrease efficacy and therefore not recommended. Potent CYP34A inhibitors (e.g. ketoconazole, itraconazole, telithromycin, clarithromycin, nefazodone) may increase exposure to ulipristal acetate. Clinical relevance unknown. **Potential for ulipristal acetate to affect other medicinal products:** Because ulipristal acetate binds to the progesterone receptor with high affinity, it may interfere with action of progestogen-containing medicinal products. Contraceptive action of combined hormonal contraceptives and progestogen-only contraception may be reduced. Concomitant use of ulipristal acetate and emergency contraception containing levonorgestrel not recommended. **Pregnancy and lactation:** Contra-indicated during existing or suspected pregnancy. Extremely limited data available on health of the foetus/new-born in pregnancy exposed to ulipristal acetate. No teratogenic potential was observed; animal data insufficient with regard to reproduction toxicity. HRA Pharma maintains a pregnancy registry to monitor outcomes of pregnancy in women exposed to ellaOne. Patients and health care providers are encouraged to report any exposure to ellaOne by contacting the Marketing Authorisation Holder. Unknown whether ulipristal acetate is excreted in human or animal breast milk. A risk to the breast-fed child cannot be excluded; breastfeeding not recommended for ≥36 hours after intake. **Undesirable effects:** Always consult the SmPC before prescribing. *Very common (≥1/10):* abdominal pain, menstrual disorder. *Common (≥1/100 to <1/10):* infections, mood disorders, headache, dizziness, nausea, vomiting, dyspepsia, muscle spasm, back pain, dysmenorrhea, menorrhagia, metrorrhagia, fatigue. *Uncommon (≥1/1,000 to <1/100):* Appetite disorders, psychiatric disorders, mood disorders, depression, anxiety symptoms, insomnia, libido disorders, irritability, somnolence, tremor, vision blurred, hot flush, diarrhoea, constipation, dry mouth, flatulence, acne, rash, pruritus, musculoskeletal pain, pollakiuria, breast pain, genital pain, uterine spasm, premenstrual syndrome, genital pruritus, vaginal discharge, pain. *Rare (≥1/10,000 to <1/1,000):* dehydration, disturbance in attention, lethargy, vertigo, sinus congestion, cough, epistaxis, dry throat, gastro-oesophageal reflux disease, glossitis, toothache, urticaria, nephrolithiasis, renal pain, chromaturia, ruptured ovarian cyst, chest discomfort, inflammation, malaise, pyrexia, thirst, chills. **Package quantities and basic NHS price:** ellaOne 30 mg Tablet Oral use 1 tablet blister pack: £16.95. **Marketing authorisation holder:** Laboratoire HRA Pharma, 15, rue Béranger, F-75003 Paris, France. Marketed in the UK by: HRA Pharma UK Limited, Unit 7, RB Building, 557 Harrow Road, Kensal Green, London W10 4RH. **Marketing authorisation number(s):** EU/1/09/522/001. **Legal category:** POM. **Date of last revision of the API text:** 18th August 2009.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to HRA-Pharma UK Ltd on 0800 917 9548 or email med.info.uk@hra-pharma.com.

Reference: 1. CHMP Assessment Report for ellaOne. Procedure No EMEA/H/C/001027. Available at www.emea.europa.eu

Further information available from:
HRA Pharma UK Ltd
Unit 7, RB Building, 557 Harrow Road, Kensal Green, London W10 4RH.
Tel. 0800 917 9548 Email: med.info.uk@hra-pharma.com

Item code: 106/ELLA/Sept/09/AS Date of preparation: September 2009

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Update

Harm reduction in substance misuse

Practical ways pharmacists can provide care to substance misusers

Nazmeen Khideja MRPharmS

Pharmacological treatment in opioid abuse should initially be supervised for up to three months as the guidance makes clear,[1,2] and this is a role that community pharmacy has embraced.[3,4]

This article considers the practical applications of providing pharmaceutical care to those under the care of substance misuse services.

The aim of harm reduction is not necessarily to eradicate substance misuse, but is a recognition that a number of valuable interventions can educate clients and enhance their quality of life. It is an evidence-based approach that impacts on the individual, those around them and society as a whole.[5] It is also a practical approach that focuses on changes as simple as injecting less or not injecting at all, reducing or moderating substance consumption, eventually aiming for abstinence.

The interventions community pharmacy can provide include methadone and buprenorphine maintenance treatment, needle exchange schemes, health promotion and signposting.

Supervised services

Supervised administration and consumption of opioid substitute medication is established as an enhanced service under the pharmacy contract.[6] The service is negotiated and agreed locally, reflecting local patterns and demographics.

Supervised consumption services should be set up in such a way that a number of key issues are properly dealt with:

- Facilities and premises should be private so that clients receive a confidential and non-judgemental service.
- The pharmacy should be integrated into a wider healthcare team to allow communication, input into care plans and feedback.
- Pharmacy procedures should be reviewed including SOPs, management of CDs, staff training and updates.

A template for the service specification is available from the PSNC website.[6]

A key point to bear in mind is that the pharmacist and pharmacy team may see a client nearly every day for up to three months. This is far more face-to-face contact than any other healthcare professional in the management of the client's condition, and for this reason community pharmacy occupies a unique position.[7]

Needle and syringe programmes

Needle and syringe programmes (NSPs)[8] are also an enhanced service under the pharmacy contract. Research has shown providing clean injection equipment can reduce risky behaviour such as sharing needles.

Nice has classified NSP into three service levels:

Level 1: Distribution of injecting equipment (pre-packed or items as needed) with written information about harm reduction.

Level 2: Distribution of injection equipment tailored to service user requirements with health promotion advice.

Level 3: As level 2 but with signposting and/or referral to specialist services.

As with supervised consumption, community pharmacies offer an attractive environment for NSP because of their accessibility, anonymity, extended opening times and the privacy allowed by private consultation areas.

Consideration needs to be given to the prevention of needle-stick injuries through policy and procedure, and protocols for the management of injury. The Nice guidance for NSPs says that staff involved with NSPs should have access to hepatitis B vaccinations, but there is currently no uniform provision of access to these vaccinations for staff and this is an issue that should be considered in risk management.

The Nice guidance also recognises the reality of secondary distribution in which one service user collects clean injecting equipment and redistributes it. Where a pharmacy operates both a supervised consumption service and an NSP, the services are symbiotic but also independent: mutual information transfer should not occur without prior consent of the client and only as part of a shared care agreement.

Blood borne viruses

Health Protection Agency figures show that up to one in 90 intravenous substance misusers have HIV and one in two have hepatitis C,[9] and sharing of syringes and other injecting paraphernalia is known to contribute to the spread.

Hepatitis C There is no vaccination for hepatitis C, but service users should be screened and managed accordingly. Community pharmacy has been involved with hepatitis C screening via dry blood spot testing in a pilot project across five PCTs.

60-second summary

The purpose of harm reduction

Harm reduction recognises that it will not eradicate substance misuse, but can educate clients and enhance their quality of life. It focuses on practical changes such as reducing the frequency

A suitable environment

Community pharmacy offers an attractive environment for supervised consumption and needle exchange schemes as they offer accessibility, anonymity, extended opening times and private consultation areas

How can community pharmacists be involved?

As well as supervised consumption services and needle exchange schemes, pharmacists can help with health promotion, oral health and wound management advice. There is also scope to become involved in thrombosis prevention and screening for conditions

This article (Module 1502) can help you provide evidence for the following CPD competencies: C1a, C1g, C1j, C1k, C1q, C1u, C1v, C3g

See http://tinyurl.com/68ox7k

With Vicks First Defence Micro-Gel Nasal Spray, chances are a cold won't take hold

Many of your customers may think you can't fight cold viruses – you can only treat the symptoms. Well, **clinically proven**[1] Vicks First Defence Micro-Gel Nasal Spray is testimony that you **can** stop a cold in its tracks. Furthermore, Vicks First Defence Nasal Spray now offers **you** and **your** customers a **Money Back Guarantee** if they are not completely satisfied.

We may all consider a cold to be a minor ailment but they can become a major inconvenience, especially if it means days off work or cancelling a night out – at best a cold can certainly impair the enjoyment of life's pleasures, from the smell of coffee to having fun at social gatherings with friends.

Treating the symptoms of a cold only masks the problem but does not actually shorten or reduce the symptoms.

Armed with the knowledge that most colds can develop into full blown symptoms all year round, wouldn't it be great if you could help your customers stop a cold in its tracks rather than wait to treat the symptoms?

Well, Vicks First Defence Nasal Spray is clinically proven to do just that.Introduced to the UK four years ago, this product still remains a breakthrough innovation in the cough and cold category and is the ONLY cold intervention product currently available.

1 Induced cold clinical study 2000149

2 Johnston S, Holgate S. Epidemiology of viral respiratory infections. In: Myint S, Taylor-Robinson D, eds. Viral and other infections of the human respiratory tract. London: Chapham & Hall, 1996: 1-38

What is Vicks First Defence Micro-Gel Nasal Spray?

Vicks First Defence Nasal Spray is not a medicine, it is a unique and sophisticated micro-gel formula containing no drug ingredients. It works in three ways to support the body's natural ability to flush out viruses before they take hold. The spray action of the product ensures that the micro-gel is transferred directly to the back of the nasal passage where cold causing viruses dock and incubate. Once there, the triple action formula creates a hostile environment, traps the virus and helps the body flush it out.

- **TRAPS**
  The viscous micro-gel flows to the back of the nose and throat, where it traps the cold viruses.
- **DISARMS**
  By trapping the virus, the gel disarms it.
- **REMOVES**
  Ingredients in the gel trigger the body to create mucus – thereby helping to flush out the trapped, inactivated cold viruses, which may cause you to sneeze.

Did you know?[2]

1. The cold is one of the most common diseases, hence the name – the common cold

2. But the common cold could also get it's name from its apparent lack of manners – it travels first class but never pays, it arrives uninvited and it can stay for a week causing disruption and mayhem

3. Colds are so common that the average adult can expect to catch between two and five every year

4. Children can suffer as many as 10 colds each year

5. Three out of four colds may occur during the winter months – another reason for the name "cold"

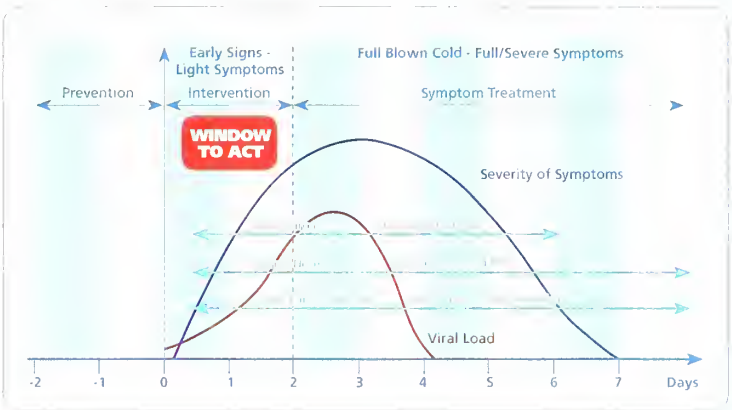
6. The rhinovirus is the most common type of cold virus

When is the most effective time to use Vicks First Defence Micro-Gel Nasal Spray?

It is a common belief that once the body has picked up a cold there is little to be done to stop it from developing. However, as the development of a cold is a process of infection, there is a window of opportunity in which to intervene and help stop a cold in its tracks– this is when to use Vicks First Defence Nasal Spray.

Vicks First Defence Nasal Spray is most effective when used within 24-36 hours after the virus enters the body. During this time sufferers will feel the first warning signs of a cold – tickly sore throat and sneezing are the most common. For optimum results, it is best to continue using Vicks First Defence Nasal Spray for two days after the symptoms have subsided.

Vicks First Defence Nasal Spray can also be taken when at risk of catching a cold or where germs can easily spread, for example on public transport, in the office, when a partner / member of the family is suffering.



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CASE STUDY – using the D.E.C.I.S.I.O.N. technique*

Mr Tee is a regular patient at your pharmacy, and is currently on his third week of supervised consumption for buprenorphine. He attends the pharmacy today as usual; you administer and supervise his buprenorphine. However, in addition he asks to take 'a pack of 1mls' from the needle exchange scheme the pharmacy offers. Mr Tee's dose has been titrated and he appears to be stable at the current dose. He doesn't seem to have any symptoms of opioid withdrawal and has been attending the pharmacy regularly since starting treatment, not missing a single day. You are concerned about him and are unsure of what to do next.

D.E.C.I.S.I.O.N. time

What would you do?

D – Define the facts and the situation

- The patient is coming regularly, taking the buprenorphine as prescribed, no withdrawal symptoms exhibited.
- Buprenorphine is a partial agonist and using other opioids may precipitate withdrawal.
- He seems to have been engaging with treatment well and you have a good relationship with him – he may be secondary distributing.

E – Ethical considerations

- Patient confidentiality.
- If you do not supply clean needles then he may share or use old ones, risking blood borne virus transmission.
- Being non-judgemental will encourage him to be open and frank with you.
- Confronting the patient may result in him dropping out of treatment.
- If you do not supply, he will just go to another pharmacy and they will not know of his prescription medicines.

C – Concrete – Consider the legality of the situation

- You are contracted under a service level agreement for essential services; being on a supervised consumption scheme does not mean you can't take part in needle exchange scheme.
- Data Protection Act and sharing of information without the patient's consent.

I – What should I do?

- Refuse to supply the needles, but signpost him to another pharmacy.
- Refuse to supply the needles and report him to the drug action team without his knowledge.
- Refuse to supply the needles and report him to the drug action team with his knowledge.
- Supply the needles without questioning him.
- Supply the needles after asking Mr Tee if they are for him and if he has any returns.

S – Someone else – what would another pharmacist in my situation do?

- What is the drug action team's advice? What do they recommend in this situation?
- What policy do other pharmacies offering the service operate?

I – I decide to...

Supply the needles after asking Mr Tee if they are for him and if he has any returns. Even if they are not for him, this is an important harm reduction strategy. If they are for him, you should attempt to maintain your relationship because you will be able to provide invaluable advice with respect to dosing of medication, titration and the dangers of concomitant illegal opioid use. This information could save his life.

O – Official – documentation, record keeping, standard operating procedures

- Seek advice from the action team and document this as part of the SOP for needle exchange and supervised consumption.
- Note your intervention on the patient's PMR and monitor the incidence of requests.
- Patient's initials and date of birth are noted on most needle exchange schemes for data collection, and patients will be monitored.

N – Next time – reflect, evaluate, discuss with peers, CPD

- Review the benefits of harm reduction strategies like needle exchange.
- Encourage all patients to bring back used needles to be disposed of as clinical waste.
- Continue to advise on health promotion matters and engage clients as equals in their care.

*__D.E.C.I.S.I.O.N.__ is a mnemonic devised by the author to help students think logically and objectively through ethical dilemmas.

Hepatitis B Hepatitis B is primarily spread by sexual intercourse but may also be transmitted by IV users. It can be prevented by immunisation programmes, and community pharmacy can encourage uptake and course completion.

HIV HIV is the least common of the blood-borne viruses, but transmission does occur.

Health promotion

Along with substance misuse, alcohol and tobacco may also be an issue and referrals should be made to local services as appropriate.

Wound management

Unhygienic injecting and dirty equipment are the main causes of infection but contaminated heroin may result in clostridial infections. 'Missing the vein' with Clostridium-contaminated heroin injections can lead to abscesses, infection and necrosis, and septicaemia. Referrals should be made early and local antibiotic policies followed.

Thrombosis

Poor injecting technique, especially into femoral veins (groin), can cause femoral venous thrombosis and embolisms.[10] There is scope for community pharmacy to become involved in anti-coagulation services for substance misusers as an enhanced service commissioned locally or as part of world class commissioning.

Oral health

Substance misuse, especially opiates, is often associated with poor dental hygiene. Rather than simply attributing this to sugared formulations of methadone, health professionals should consider overall diet, dental hygiene, xerostomia (reduced saliva production due to opiates) and also methadone's smaller analgesic effect compared with heroin: analgesia due to heroin may disguise dental cavity pain. These factors and the client's engagement with treatment frequently bring their poor oral health to light.

Drinking water after supervised consumptions, chewing sugar-free gum and signposting to services can all help.[11]

STDs and contraception

STDs such as hepatitis may be transmitted through sex. Safer sex advice should be given at every point and condoms may be included in NSP packs at level 1. Also, menstrual irregularities due to opiates may disguise pregnancies. Clients should be signposted to sexual health services and encouraged to take part in screening programmes such as cervical smears.[11]

MURs

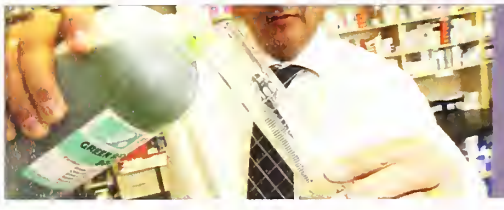
Community pharmacists are in a unique position to build a rapport with clients on maintenance treatment and should consider MURs in this patient group, discussing medication and the effect of missed doses as well as health promotion signposting and referrals. Patients may have a dual diagnosis for other mental health issues and pharmacists may be able to help with compliance.

Role of support staff

All pharmacy staff should be encouraged to take part in the pharmaceutical care of patients with substance misuse issues. This includes providing a non-judgemental environment and maintaining privacy and confidentiality. Additionally, pharmacy staff should be alert to over the counter purchases of substances liable to misuse and highlight these to the pharmacist accordingly.

Nazmeen Khideja MRPharmS is a teacher practitioner at University of Wolverhampton Pharmacy Department and addiction services consultant, Dudley Drugs Project.

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online.



NEXT WEEK
Frequently asked questions about CD supplies to drug misusers

Harm reduction in substance misuse

What factors should you consider when offering a supervised consumption of medicines service? What is involved in the different levels of service of needle and syringe exchange programmes?

This article describes how pharmacists can become involved in harm reduction, including information about supervised administration and needle and syringe exchange services. Other harm reduction services are discussed, and a case study deals with a dilemma that may occur during supervised consumption.

Read the two previous Updates in this series about addiction and its treatment if you have not already done so, online at www.chemistanddruggist.co.uk/update

Find out more about harm reduction from the UK Harm Reduction Alliance website at http://tinyurl.com/atwpq

Find out more about when supervised consumption should be used, on the NHS CKS website at http://tinyurl.com/ybpwx74

Read the frameworks for enhanced services for supervised consumption and needle and syringe exchange on the PSNC website http://tinyurl.com/ya6vy9m and at http://tinyurl.com/yd5dcem

Update your knowledge of the services available in your area. Think whether you could provide them.

Are you familiar with supervised consumption and needle and syringe exchange services? Are you confident in your knowledge of other harm reduction services pharmacists could provide?

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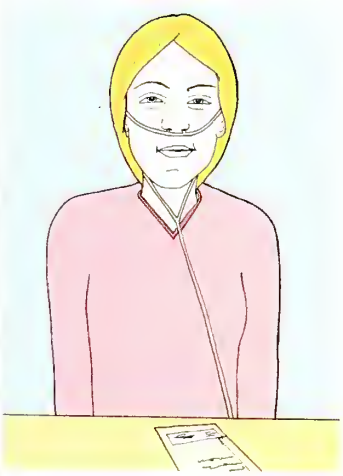
Practical Approach

Cystic fibrosis therapy



David Spencer, pharmacist at the Update Pharmacy, is on prescription reception. Tracey Thomas, a young woman who has cystic fibrosis, hands over to David a prescription from her GP. He looks at it and says: "Hello Tracey. This is a bit unusual, isn't it? The prescriptions you usually bring in are issued from the hospital respiratory outpatient clinic?"

"That's right," Tracey replies, "but last time I went they were terribly behind and I was going out somewhere straight afterwards. I rushed off without waiting for the script and then just forgot about it. That is until I realised I was nearly out. I didn't want the hassle of going all the way back and waiting in the clinic again, so I phoned Dr Adi-Varli's surgery and explained what had happened. They were really sweet, Dr Adi-Varli looked up the notes she had from the hospital and wrote a script for me to pick up."

David looks at the prescription, which is for Promixin 1 million units powder for nebuliser solution. He then asks Tracey to wait while he checks her PMR, which shows that she has previously always had Colomycin injection 1 million units powder for reconstitution. David is not familiar with Promixin. He goes back out to Tracey and tells her he thinks he ought to check with the hospital before ordering and supplying it.

Questions

1. What are Colomycin and Promixin and what are they prescribed for?

2. David asked the hospital pharmacy if he could supply Promixin instead of the usual Colomycin. What was the pharmacy's reply?

3. Patients may receive medication prescribed or supplied by someone other than their GP. When conducting MURs, what questions should be raised with the patient to ensure that they are not using duplicated or incompatible medications?

Answers

1. They are both presentations of colistimethate sodium, a polymixin antibiotic. Both can be given via inhalation of a nebulised solution as an adjunct to standard antibacterial therapy in patients with cystic fibrosis.

2. Yes, because although Promixin is preferably delivered using an adaptive aerosol delivery breath-actuated nebuliser, it can be inhaled via a standard ultrasonic nebuliser. The hospital uses Colomycin injection because it can be used for nebulisation and it is cheaper than Promixin.

3. Do you receive any medicines regularly from hospital outpatient clinics?

Have you recently been admitted to hospital? (If so, try to obtain a record of any discharge medication).

Do you get any medicines or appliances other than those prescribed by your GP?

Are you cared for or seen regularly by any practitioners outside your GP's surgery? (Something that even the patient's GP may be unaware of).

Do you take any medications not prescribed by your GP for which specific monitoring is required?

Are you on any medications not taken by mouth (eg injections, via nebuliser, etc)? Many patients consider that questions asked by the pharmacist refer only to oral therapy.

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Pfizer *Listening to pharmacy*

A change of heart

Is aspirin coming to the end of the road in primary cardiovascular prevention? Maybe, but expect a raft of trial results before it's decided, says **Gavin Atkin**

Is the tide turning for aspirin in primary prevention of cardiovascular disease? It certainly seems so after the past couple of months. First, in September, Scottish officials writing draft guidelines decided they could not recommend aspirin for primary prevention in diabetes patients because recent trials had increased uncertainty about its role. The Scottish Intercollegiate Guidelines Network (SIGN) observed that in two studies aspirin had failed to show a significant reduction in cardiovascular outcomes. Both studies, said the SIGN guideline authors, should be considered in the context of the HOT study, published in the late 1990s, which showed a significant increase in major bleeds in patients receiving aspirin.

Then, in October, the drugs regulator MHRA issued a drugs safety update reminding healthcare professionals that aspirin was not licensed for primary prevention of vascular events. And as C+D went to press this week, the Drug and Therapeutics Bulletin called for the abandonment of aspirin in patients yet to develop "obvious" cardiovascular disease (see p6). Yet it was only in March that the US Preventative Services Task Force came out strongly in favour of aspirin in primary prevention – and even described the strength of the evidence as "grade A".

So what's going on here? The fact is that while there is little or no argument about the usefulness of aspirin in secondary prevention, the idea that this cheap, widely available antiplatelet drug is also effective in preventing a first myocardial infarction (MI) or ischaemic stroke has had a much rougher ride going back at least as far as the late 1980s. It's also true that aspirin has taken some particularly big knocks in the weeks between the US recommendations and the recent spate of contradictory advice.

Initial interest came in the early 1980s, when it was found that the antiplatelet effects of aspirin might benefit patients with heart disease, says Oxford University epidemiologist Professor Colin Baigent. "Long-term studies in people with a previous heart attack showed it was effective in preventing recurrences," says the Medical Research Council-sponsored researcher. "So then people wondered about primary prevention: could we prevent a first event in people who are apparently healthy? If aspirin is so good at preventing a second event wouldn't it be even better if it prevented a first event?"

The first studies were done in physicians: the British Doctors Study and the US Physicians Health Study. The smaller British study produced a negative result, but the American study was strikingly different – it showed such large reductions in rates of first MI that it was discontinued early. Figures from the trial showed a 44 per cent reduction in risk of MI and a small rise in stroke risk that did not reach statistical significance.

The appeal of this cheap, widely available drug that could save lives was clearly strong. However, researchers have often been unable to agree on the answer to the question of whether the

Three new studies have raised questions over aspirin for primary prevention even in high risk groups

increased risk of gastrointestinal bleeds and intracerebral haemorrhage noted by HOT cancels out the reduced risk of MI and ischaemic stroke. Nevertheless, for some time the accepted view was that diabetics were at such high risk of cardiovascular disease that they should be treated as if they already had it – and should be treated with aspirin.

But three new studies have raised a big question mark over the use of aspirin even in high risk groups. The first two – the POPADAD study in Scottish diabetics published in October last year and the JPAD study in Japanese diabetics published a few weeks later – were both carried out in patients with no evidence of heart disease, and neither showed a difference between aspirin and control. "When taken together with other evidence in people with diabetes, it was perceived that the evidence for taking aspirin in patients with diabetes who are at low risk was pretty weak," says Professor Baigent.

The third study, from Professor Baigent's own group, added still further to the evidence – and seemed to bring some new understanding to the issue. "What we did was to look at studies that have been completed in people that appear to be healthy. We brought together all the data that was in those trials, which included 95,000 subjects, and re-crunched it.

"We found that the pattern of effects of aspirin in primary and secondary prevention are similar: in each case the relative reduction in risk of a heart attack is about a quarter. But because the absolute risk in primary prevention is an order of magnitude smaller, the benefit of taking aspirin is also much smaller."

In fact, the figures show that the absolute reduction in mainly non-fatal heart attack is about twice as big as the increase in absolute risk of bleeding. If that's true, why not use it?

It is true, says Professor Baigent, but the issue is more complicated. The reason why aspirin treatment to prevent cardiovascular events in large numbers of patients would be inappropriate is partly a matter of scale but also down to the evidence for other ways of preventing cardiovascular events: "The problem is that – just like giving a vaccine on a large scale – if one is going to use aspirin for primary prevention on a large scale you want to be really sure it's safe.

"But more than that there are now much safer ways to reduce risk in the general population. Obviously we'd recommend people give up smoking, but if they're not a smoker in these times the obvious treatment to reduce risk would be statin therapy.

"Statins have been reliably demonstrated to reduce both fatal and non-fatal heart attacks and, although they can cause rhabdomyolysis, it's extremely rare. It makes more sense to begin your primary prevention with a statin and a blood pressure lowering drug if that can be tolerated, and only then to consider whether aspirin is appropriate."

Now here's the rub: if before you start considering aspirin you have already reduced the patient's risk of an event possibly by as much as a half using lipid lowering and antihypertensive therapies, then the balance of risks and benefits of adding aspirin are likely to be equal – numbers of additional bleeds and haemorrhages are likely to be roughly comparable with the numbers of prevented MI and ischaemic strokes. In effect, it becomes still harder to see how the reduced benefits of aspirin treatments can justify aspirin's negative effects, says Professor Baigent.

"It's a drug that has very small benefits and very small hazards, and they seem to be about the same size. So it doesn't make sense to use it for primary prevention in large sections of the population," he concludes.

Professor Baigent's analysis found another interesting point, he reveals. "In previous exercises where people have brought together modelling evidence, it has been assumed that the risk of bleeding has been relatively constant in different groups.

"By pooling the data from different studies we've shown that to be a really gross miscalculation – it turns out that the risk factors for heart attacks are largely the same as those for both gastrointestinal bleeds and intracerebral haemorrhages, so the very people who stand to gain most from aspirin also stand to lose most."

But that's not the end of the story for aspirin – not by any means. A powerful body of opinion continues to support aspirin, as the US Preventative Services Task Force guidelines published earlier this year show. Also, there are a number of upcoming studies in patients with diabetes designed to identify groups of high risk diabetes patients who might benefit from aspirin. These are expected to throw more light on the issue in the next several years: the ASCEND trial looking at both aspirin and fish oils in diabetes has been underway since 2004; the Italian ACCEPT-D trial examining the benefits of aspirin and statins has begun more recently; the US National Institute of Health is running the ASPREE study of aspirin in the elderly; and aspirin manufacturer Bayer is sponsoring the ARRIVE study of aspirin in a range of patients at high risk of cardiovascular events.

However, Professor Baigent believes he already knows what many of these studies will find, given the conclusions of his own work. "My own prejudice is that where risk of MI is high, risk of gastrointestinal bleeding and intracerebral bleeding is also high and that this will prevent a clear answer from emerging, particularly if the patients are already using a statin or blood pressure lowering drug to reduce risk."

Need to know: advice for healthcare professionals

- Results of recent studies lend support to the licensed indications for aspirin in secondary prevention of vascular events only.
- Aspirin is not licensed for the primary prevention of vascular events. If aspirin is used in primary prevention, the balance of benefits and risks should be considered for each individual, particularly the presence of risk factors for vascular disease (including conditions such as diabetes) and the risk of gastrointestinal bleeding.

Source: Drug Safety Update, MHRA, October 2009

References

- **Scottish Intercollegiate Guidelines Network (2009)**
Open consultation on the draft guideline on the management of diabetes.
www.sign.ac.uk/guidelines/drafts/index.html

- **Antithrombotic Trialists (ATT) Collaboration (2009)**
Aspirin in the primary and secondary prevention of vascular disease: collaborative meta-analysis of individual participant data from randomised trials, Lancet 373: 1849-60.

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QUANTUM SPECIALS

For more from Jonathan Mason, check out his blog

Building relationships with your local doctor is well worth the time and effort, **Chris Chapman** heard at the C+D Conference in Birmingham last month

How to work with GPs

Cast your mind back to the neon blare of the early 1980s. The cold war is in full swing, Duran Duran are competing with Queen in the charts, and Jonathan Mason's pharmacist dad has invited a GP round for tea.

"A number of GPs used to come to our house to discuss issues over a glass of wine," the government's community pharmacy tsar told the C+D Conference in Birmingham last month. "If you have these relationships, you will increase your business."

The potential benefits of a good relationship make a compelling argument for even the most misanthropic pharmacist to reach out to nearby GPs. Good relationships improve patient care through shared understanding, speed up responses to queries, and can present opportunities for more targeted services. For example, Mr Mason explains: "MURs are best for patients for whom GPs see added benefit. You may see GPs refer patients to you, rather than you needing to go and find them."

Doctors also hold a lot of clout with PCTs, Mr Mason says. By engaging with local doctors, he believes GPs can "become your strongest advocates" to get services commissioned, either through the PCT or practice-based commissioning.

But building such relationships is not easy. The most frequent interaction a pharmacist will have with a GP is to clarify a prescription or highlight an error. And with similar services up for commissioning grabs, it is all too easy for professionals on both sides of the divide to view each other as rivals rather than as part of the same team.

Mr Mason believes such thinking is flawed. Commissioners are looking to service the entire community, he says, and need to commission services from a wide range of healthcare providers to fulfil their remit. "Not all people want to go to a GP," Mr Mason explains. "We need to sell the accessibility of pharmacy... everyone can have a slice of the pie."

Face to face interaction with GPs is the best way to build a constructive relationship

Deborah Evans, director of community pharmacy consultancy Balance, says the secret to overcoming the competition hurdle is to convince local GPs you're working toward the same goals. "Think about finding a common ground," she told the C+D Conference, suggesting waste reduction and unplanned admissions, patient adherence, integrating services and delivering patient care closer to home as possible areas of shared interest. She says: "By integrating [care with GPs], the patient gets to see the right professional at the right time."

One of the strongest cards to play is going out and meeting your local GPs. Speaking to someone on the other end of the phone lacks the impact of a face to face meeting, and Ms Evans recommends interacting personally as often as possible. She says if you can't get to the local practice, encourage the practice staff to come to you: hold an open evening at the pharmacy to show what you can offer, or invite the doctors to pop in. "It's about opening a dialogue," she explains, "taking the time to meet and speak, not just as a one off."

Working in partnership isn't just about your GP giving you what you want, though. Ms Evans says it's well worth taking time to understand what's on their mind to work through issues together. "Make sure you listen. It's really important to listen in a reflective way, and make sure the GP understands you've heard them... if you can get the doctor to verbalise the problem, then you can offer a solution."

If you do find yourself in direct conflict with the GP, Ms Evans suggests the best tactic is often to take a step back and look at the causes rather than taking it personally. "Be soft on people, hard on the issue," she says. "Recognise concerns, focus on the issue, and don't make it personal."

Relationships don't blossom overnight. Building a strong partnership in which both your pharmacy and the local GP practice benefits takes time and hard work. Ms Evans says that it's important that you think clearly about what you want to achieve from your combined efforts, allowing you to maximise your efforts.

Ultimately, pharmacists and GPs share the same goal: to help their patients. And pharmacists can reap rewards for their business when they work with their local practice. But the greatest reward, says Ms Evans, is the professional satisfaction gleaned from a positive relationship.

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Approximately 1.5-2 g/10 cm^2 EMLA applied for a minimum of 2 hours, maximum 5 hours. ***Mole genital skin*** (apply a thick layer of cream under an occlusive dressing). Prior to injection of local anaesthetic. Approximately 1 g/10 cm^2 EMLA applied for 15 minutes. ***Genital mucosa*** (adults) (no occlusive dressing required). For surgical treatment of localised lesions. Up to 10 g EMLA for 5-10 minutes. Commence procedure immediately thereafter. Analgesic efficacy may decline if the skin application time is more than 5 hours. Procedures on intact skin should begin soon after the occlusive dressing is removed. On the genital mucosa analgesic efficacy declines after 10-15 minutes and therefore the procedure should be commenced immediately. **Children.** ***Skin*** (apply a layer of cream under an occlusive dressing). Prior to small procedures e.g. needle insertion or minor skin operations. Application time: approx. 1 hour. ***Term newborn infants and infants under the age of 3 months (or < 5 kg):*** Up to 1 g on a maximum application area of 10 cm^2. Application time: 1 hour, not more. Only one single dose should be given in any 24 hour period. ***Infants aged 3-12 months (and > 5 kg):*** Up to 2 g on a maximum application area of 20 cm^2. Application time: approx 1 hour, maximum 4 hours. ***Children aged 1-6 years (and > 10 kg):*** Up to 10 g on a maximum application area of 100 cm^2. Application time: approx 1 hour, maximum 5 hours. ***Children aged 7-11 years (and > 20 kg):*** Up to 20 g on a maximum application area of 200 cm^2. Application time: approx 1 hour, maximum 5 hours. A maximum of 2 doses at least 12 hours apart may be given to children over 3 months of age (and > 5 kg) in any 24 hour period. Prior to curettage of mollusca in children with atopic dermatitis, an application time of 30 minutes is recommended. Analgesic efficacy may decline if the skin application time is more than 5 hours. Procedures on intact skin should begin soon after the occlusive dressing is removed. **Contraindications:** Known hypersensitivity to anaesthetics of the amide type or to any other component of the product. **Precautions:** EMLA should not be used in pre-term neonates i.e. gestational age less than 37 weeks, or in infants/neonates between 0 and 12 months of age receiving treatment with methaemoglobin-inducing agents due to the possible additive effects. In infants younger than 12 months a transient, clinically insignificant increase in methaemoglobin level is commonly observed up to 12 hours after on application of EMLA. Patients with glucose-6-phosphate dehydrogenase deficiency or congenital or idiopathic methaemoglobinaemia are more susceptible to drug induced methaemoglobinaemia. Methaemoglobinaemia may be accentuated in patients already taking drugs known to induce the condition e.g. sulphonamides. Do not apply to any wounds or mucous membranes, in addition do not apply to genital mucosa in children. Care should be taken when applying EMLA to patients with atopic dermatitis. A shorter application time, 15-30 minutes, may be sufficient. Care should be taken not to allow EMLA to come in contact with the eyes as it may cause eye irritation. Also the loss of protective reflexes may allow corneal irritation and potential abrasion. If contact with the eye occurs, immediately rinse the eye with water or sodium chloride solution and protect it until sensation returns. EMLA may be ototoxic and should not be instilled in the middle ear nor should it be used for procedures which might allow penetration into the middle ear. Caution should be exercised in patients with anaemia, congenital or acquired methaemoglobinaemia or patients on concomitant therapy known to produce such conditions. Patients treated with anti-arrhythmic drugs class III (e.g. amiodarone) should be under close surveillance and ECG monitoring considered, since cardiac effects may be additive. Lidocaine and prilocaine have bactericidal and antiviral properties in concentrations above 0.5-2%. For this reason, the results of intracutaneous injections of live vaccines should be monitored. The risk of additional systemic toxicity should be considered when large doses of EMLA are applied to patients already using other local anaesthetics or structurally related drugs e.g. mexiletine. Specific interaction studies with lidocaine/prilocaine and anti-arrhythmic drugs class III (e.g. amiodarone) have not been performed, but caution is advised. Studies have failed to demonstrate efficacy of EMLA for heel lancing in newborn infants. Use with caution in women who are pregnant or breastfeeding. **Undesirable** events: Common: Transient local reactions at the application site such as paleness, redness and oedema, local sensations (an initial, usually mild, burning sensation, itch or warmth) at the application site when used on genital mucosa. Uncommon: Local paraesthesia such as tingling at the site of application, an initial mild burning or itching sensation at the application site when used on intact skin. Rare: Corneal irritation after accidental eye exposure, methaemoglobinaemia in children - methaemoglobinaemia is more frequently observed in neonates and infants aged 0 to 12 months, often in connection with overdose. Rare cases of discrete local lesions at the application site, described as purpuric or petechial have been reported, especially after longer application times in children with atopic dermatitis or mollusca contagiosa. In rare cases local anaesthetics have been associated with allergic reaction including anaphylactic shock. **Legal category:** P. **Marketing authorisation number:** PL 17901/0120. **Basic NHS cost:** "Pre-medication pack" containing 5 x 5 g tubes EMLA and 12 occlusive dressings £9.75, 1 x 30 g tube £10.25, "Dispensing Pack" containing 1 x 5 g tube £1.73, "OTC Pack" containing 1 x 5 g tube and 2 occlusive dressings – non-prescribable and available through retail pharmacy direct purchase only £2.99. **Further information** is available from the **Marketing Authorisation holder** AstraZeneca UK Limited, 600 Capability Green, Luton, LU1 3LU, UK. EMLA is a trademark of the AstraZeneca group of companies. AZ 11/08

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CZ002173-EMLA September 2009

Safety by design

Long hours and lack of breaks dominated debate around dispensing errors this year, but what about the drug packaging itself? **Emma Wilkinson** investigates how manufacturers can help pharmacists minimise the possibility of a mistake

Poorly designed packaging that overemphasises the brand can make it difficult to distinguish between products

In April this year the criminal prosecution of Elizabeth Lee under the 1968 Medicines Act for a single dispensing error caused outrage among pharmacists. The subsequent calls for the decriminalisation of such one-off mistakes hit the national press, and the case also raised several issues about safer working practices. One problem that has long been highlighted by the profession as a cause of avoidable errors is poorly designed packaging – generic and branded – that makes it difficult to distinguish between products.

Packaging that places the emphasis on recognising the brand rather than the product or any safety information will inevitably add to the risk of human error; it is estimated that a third of medication errors in the NHS are caused by confusion over packaging and labelling instructions.

And although manufacturers have recognised this as a potential problem in recent years and taken steps to make pack designs safer, pharmacists warn there is still great variation. Melinda Setanoians, who works for a multiple pharmacy chain in Wishaw, Scotland, says: "Although there have been improvements in pack design, this improvement isn't consistent across, or even within, medicine manufacturers.

"Every medicine delivery to the pharmacy will typically contain a number of products that require close scrutiny to distinguish," Ms Setanoians explains. "Community pharmacists spend a considerable amount of their time ensuring that procedures are in place to circumvent any potential errors that may occur as a result of poorly designed packaging."

She adds that pharmacists understand that generic suppliers wish to enhance brand recognition by using uniform colours and fonts on their packaging – but that uniformity can contribute to dispensing errors and endanger patients. Professor David Cousins, head of safe medication practice at the National Patient Safety Agency (NPSA), agrees: "It's really important that medicines look different. The idea of corporate branding, that's the last thing you want in terms of patient safety."

In a recent NPSA report, half of incidents were put down to wrong dose, omitted medicine or wrong medicine, and there is plenty of evidence that packaging is a factor in medication errors, both for pharmacists and patients.

"Mis-selection is common," Professor Cousins says, "although it's not as simple as saying that it is about similar names or pack design as there are lots of factors involved."

Generics manufacturers have done a lot to redesign packs in recent years, Professor Cousins

Five ways to improve pack design

1. Ensure a clear space for a dispensing label where the generic name and product strength can be clearly marked.
2. Include the medicine name, variant, strength, form and number of tablets on three non-opposing sides of the pack.
3. Text must read in the same direction.
4. Minimalist design so images don't interfere with key medicine information.
5. Colour to make key information stand out.

Source: Design for patient safety, NPSA/The Helen Hamlyn Research Centre, Royal College of Art

stresses, and the UK industry is leading the way compared with Europe and the USA. A spokesman for the medicines regulator MHRA tells C+D that significant changes to packaging by generics manufacturers in the wake of its 2003 guidance has reduced the likelihood of errors. So what does safer packaging design look like?

One thing that regulators and the NPSA agree on – although some pharmacists called for it after the Lee case – is that colour coding packs is not the answer. People perceive colours differently and it may create mistakes by encouraging short cuts, according to the MHRA and NPSA view. But colour coding does have a role in packaging safety if it is used to make information stand out.

Quick recognition is the key to safe pack designs, industry experts advise. There should be a clear space for a dispensing label with the generic name (which should be clear on all packs including branded medicines) and product strength above it. The medicine name, variant, strength, form and number of tablets or capsules should all be visible on three non-opposing sides of the pack, and preferably more, so the information is clearly visible whichever way you pick the pack up. The text must also read in the same direction to avoid the need for "flipping". Too much cluttering of text and images must be avoided, and images or logos should not interfere with the text.

Typography is also critical, for example to avoid confusion over medicines with similar names, such as chlorpropamide and chlorpromazine; the NPSA recommends using capital letters on the part of the name containing the medicine characteristic.

But what particularly concerns Professor Cousins is that the lack of regulation around pack design means any changes are voluntary. He says: "Medicines regulators don't really understand that humans make errors so there's no requirement for packaging to look different – the legislation is weak in this regard."

Pharmacists often do not realise they cannot rely on regulators to make packs safe, and that they must push for it themselves, the NPSA chief adds. "Prevention is better than cure and if you see a pack that might be a problem, do you really want that in your pharmacy? Error prone packs should go into the incident book. You have a choice of generics, so you can hit suppliers in the pocket."

To date, secondary care has been much more successful at pushing for better packaging, with the NHS refusing to purchase potentially dangerous medicines even if it means going for a more expensive version. "Purchasers need to take it seriously and more could be done in community pharmacy to highlight packs that are not suitable," Professor Cousins says.

Paul Fleming, chair of the regulatory group of the British Generic Manufacturers Association and a pharmacist, says they would welcome more feedback from pharmacists but a lot of work had gone into packaging in recent years.

"There is still more that can be done but our members have a very high level of awareness about this and we regularly talk about what can be done to improve the safety of packaging."

Looking to the future, it will perhaps be greater use of technology, as well as clever design, that improves safety at the dispensing stage. Kim Innes, commercial director at Teva UK, also believes generic companies are ahead of branded pharma in terms of using colour and typography to aid recognition. She comments: "Over the next 10 years we expect to see greater use of technology in pharmacy – it will become another tool to help patient safety. The changes will, we think, be evolutionary, with a lot of thought put into extra identity cues such as colours, layout or maybe even textures."

Tools such as barcode readers, including ones that provide audio of the product name, will become part of the process, she says. "Subtle or technology-driven visual and sensory clues will become more important, and the process will continue to be refined. Errors can't be eliminated altogether, but what we can do is support pharmacists in their drive to minimise the risk of errors in dispensing."

The types and most common causes of dispensing errors and near misses

TYPES

- Labelling error **33 per cent**
- Selection error **60 per cent**
  - Wrong drug/form
  - Wrong strength
  - Wrong quantity
- Bagging error **7 per cent**

MOST COMMON CAUSES

- Misread prescription **25 per cent**
- Similar drug names **17 per cent**
- Selecting previous drug or dose from medication record **11 per cent**
- Similar packaging **8 per cent**

Source: Pharmacoepidemiology and Drug Safety 2005; 14: 327-332

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The volunteering experience

Pharmacist Anna Haynes is boosting her CV by teaching pharmacy in Africa with VSO

Learning a language called Runyankole, a five-hour drive along horrendous roads and improvising with bricklayers' trowels to make ointments are just some of the things I have experienced in my year teaching pharmacy in Uganda, but I would recommend it to anyone.

I started to research the idea of doing voluntary work abroad as a pharmacist a couple of years ago, and the organisation VSO appealed to me because of its motto Sharing Skills, Changing Lives, which means the process is sustainable.

It was quite a relief to finally arrive in Uganda with my husband Jason in February – after sorting out rental of our houses, handing in notice for our jobs, getting medicals and dental examinations done, and attending numerous VSO training courses. We decided to get married just two weeks before we arrived in Uganda, which compounded the stress even more.

During an initial week of in-country training in the capital Kampala, we learnt about Ugandan culture, had some training in the language Runyankole (local to our destination of Mbarara), and found out more about our placements. It was also a very good opportunity to meet other volunteers and build up a support network. Then it was off to Mbarara, a five-hour drive on some of the worst roads I have experienced.

The lab may have very little equipment, but Anna's improvisation saves the day

In the pharmacy department of Mbarara University of Science and Technology (MUST), just a few minutes' walk from my flat, I teach modules in community pharmacy and pharmaceutical technology. Lectures take place in a classroom that can comfortably seat 20 students, although there are more than 35 in one of the year groups.

Practical sessions are conducted in an old laboratory that has very little equipment – so my biggest challenge has been learning how to improvise. For example, we do not always have the right ingredients for extemporaneous dispensing sessions, so we have to substitute with things like sugar, salt and fruit squash.

This week the students were making ointments, although we had no ointment slabs or spatulas for mixing; I scoured the shops and the most appropriate substitutes I could come up with were some plastic chopping boards and some bricklayers' trowels. The unreliability of the power supply can also be a big problem, especially when I am lecturing and want to use an LCD projector – I am still trying to perfect writing with chalk.

There are currently just over 300 qualified pharmacists in Uganda, serving a population of more than 30 million people; that equates to only one pharmacist per 100,000 people.

There are many community pharmacies in Uganda, but they do not always have a pharmacist available to give advice; the law here says that there only needs to be a pharmacist present for 40 per cent of the time the pharmacy is open.

In my experience, you can buy whatever you want from a Ugandan pharmacy with no questions asked and little counselling given, and with scant regard as to whether the drug is prescription-only or not.

The thing I am most proud of achieving is helping to develop a new curriculum. The previous pharmacy degree syllabus included hardly any practice content until the final two years of the course, and myself and my colleagues wanted to ensure MUST produces pharmacy graduates who are competent and able to apply theoretical knowledge to clinical practice.

Now, our final year students have recently started going on ward rounds in the hospital next to the university, learning how to communicate with patients and other health professionals and how to address problems with drug therapy.

I do miss the UK, especially my family and friends. Since we've been here we've missed three weddings, and I will not see my new niece or nephew until (s)he is six months old. Life can be frustrating at times, but on the whole it is an amazing experience.

We have lovely weather all year round, and are lucky to live only a few hours drive away from some beautiful national parks. One of the highlights of my trip so far is doing a quad bike safari at Lake Mburo National Park – we managed to get really close to the animals.

I do miss being a community pharmacist in Liverpool, but I am learning so much by being out here. When I come back to the UK next June, I think I would like to be involved in education in some way, maybe by finding a job as a teacher practitioner while still working a few days a week in pharmacies.

Volunteering abroad offers exciting life experiences, as well as a CV boost

Anna's CV

2002
Graduated with MPharm from Liverpool John Moores University
2002-2004
Lloydspharmacy pre-reg in Rainhill, then branch manager in Liverpool
2004-2005
Superdrug pharmacist, Bootle
2005-2009
Rowlands pharmacist manager in Liverpool and Kirkby areas
2009-present
Pharmacist lecturer, Mbarara University of Science and Technology, Uganda

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Postscript...

Mike Hewitson's diary of a new pharmacy owner

Something smells fishy

It is fair to say most pharmacists don't get this sort of problem. It is also fair to say that I never had this sort of problem before, either. It all began with a phone call...

"Is that the pharmacist?" the voice enquired.

"Yes" I replied.

"I need you to make something for me..."

"Umm, what is it? I'll see if I can help."

"It's a bit unusual." I got the feeling in the pit of my stomach that you get at the top of a roller coaster. "I need to transport some trout sperm!"

Last time I checked, I wasn't offering a fishy IVF clinic. Nothing in the training or the Code of Ethics prepares you for a query like that. The local fish farmer wanted a mixture made to extend the life of his rainbow trout semen, so he could transport it more easily. I like a challenge as much as the next man, but could I really have met my match?

I got on the phone, first to the NPA, where I think I won the craziest query of the month award, then to the ever-unflappable Craig and Hayward.

They couldn't help, but I did get a warning: some specials companies won't touch veterinary products because some of them can be quite explosive! Things were getting better and better...

I finally tracked down a supplier who would be prepared to make it, but after all of that I'm not sure it's worth the hassle. Trout 1 Mike 0.

> I LIKE A CHALLENGE AS MUCH AS THE NEXT MAN, BUT COULD I REALLY HAVE MET MY MATCH?

Hearty congratulations to Slough pharmacist Bobby Mehta, who has picked up a certificate of achievement from the RPSGB thanks to his tireless community work. As well as running a busy Rowlands pharmacy, Bobby (pictured left, with Dr Bob Green) also helps out at his local health centre, running a smoking cessation clinic and acting as the surgery's only pharmacist independent prescriber. Bobby is also keen to promote healthy living in the community. Since 2001 he has worked with local colleagues and friends to form Sunday Morning Soccer, a non-profit voluntary group that's raised around £2,000 for charity. To find out more, pop on to Bobby's website www.officialsms.com

Raiders of the lost archives

C+D 1859-2009 Celebrating 150 years in pharmacy

C+D had a little rant about doctors' handwriting back in 1860, when a reader finally snapped and sent in a sample of the local physician's illegible scrawl.

"This evil of bad penmanship crops up in every profession," C+D said, asking "what money is wasted every year, what blunders are committed, what precious time is thrown away, what human misery is caused, by this neglect to master the commonest of all the mechanical arts?"

Doctors had to have "an excellence of penmanship above all other professions", C+D insisted, pointing out that "a mere speck of ink" could alter the meaning of a prescription.

But C+D's editor wasn't finished there, continuing his tirade as he lambasted medical scribbling for another hundred words of irate ranting. "We have no doubt our readers could furnish us with a thousand similar instances of medical carelessness, not to say ignorance," he concluded.

We'd hate to think what he'd make of today's txtspk, lol :).

Nit good news from the X Factor

Postscript has been following the latest batch of pop star wannabes in this year's series of the X Factor: there's the one with the tragic life story, the one with the even more tragic life story, the unfathomably popular one and the one Louis Walsh keeps chirping on about as having "likeability". But according to a national newspaper, the contestants may be in need of a trip to the pharmacy.

The Daily Telegraph has reported a suspected outbreak of nits in the X Factor contestant house, with several of the prospective superstar warblers scratching their heads in frustration. According to newspaper The Sun, fingers are being pointed firmly at one of the acts, even though the outbreak has not been confirmed, adds the Daily Telegraph.

Postscript hopes the contestants are able to scratch that itch as the show goes on, and is eager to see our favourite contestant, Olly, continue in the competition. After all, his surname is Murs...

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